System Transformation Initiative

Task Force Meeting 10/19/06
Notes

INTRODUCTORY COMMENTS

We are basing this task force process on the model we used from the Cross-System Crisis Response task force in which some of you participated. The difference is that this process is driven by the legislature and carried out through the Mental Health Division (MHD) vs. the grassroots approach used before.

In reference to the timeline "final reports:" Another difference is that our consultants will be writing the reports, not the task force members; the task force will be providing guidance and input to the consultants for these reports.

Richard Kellogg: I encourage you to be idealistic and visionary, while also understanding the need for a budget neutral process.

Comment from the Group: This isn't a second course. I really encourage you to align with the Transformation Grant efforts since there has already been a lot of work on many of these issues.

Kellogg: This is an opportunity for convergence ~~(~~between System Transformation Initiative (STI)and Transformation Grant~~)~~. It is also important to understand the difference between the process driven by the Executive Branch (Governor's Office) for the Transformation Grant vs. this process (STI), which is driven by the Legislative Branch.

Kellogg: We are open-minded about moving in the next legislative session, especially with regard to ITA.

STI BACKGROUND

Questions:

- Slide #5: State Hospital Increases 2005-2006
  Comments:
  - Western providers have had a harder time getting beds for short term commitments
  - 90-day commitments decreased in King County, freeing capacity at Harborview and West Seattle inpatient units for 14-day commitments
  - On the Eastside, the situation worsened because community hospitals are taking Westside patients and now we have a constant wait list and no local capacity.
- Slide #7: State Hospital Average LOS for In-Resident Civil Population
  Comments:
  - Regarding length of stay at WSH, it would be helpful to look at the data again if you separate geriatric beds from the rest of the population.
  - It would also be helpful to pull out re-admission rates
- Slide #8: PALS is involuntary and less restrictive. The assumptions here are that the pre-existing number of beds were the appropriate number.
- Slide #11: STI Implementation Values
  Comments:
  - Add "looking at rural vs. urban differences"

PACT

Concerns and Questions:

- There are some concerns that this model is coercive. The word "assertive" implies coercive behaviors.
  - Response: There has been much work in this area, particularly bringing in the individual consumer's preferences and needs and working within that.
  - The term "assertive" pertains to the outreach needed within this model and the philosophy that the provider should try all that is needed to help the consumer.
- Is PACT a voluntary service?
  - Response: Yes, individuals served on PACT teams have the same rights as other individuals treated with any other community-based mental health treatment. In some cases individuals may meet the criteria for outpatient commitment, which is the same process as it would be for any other community-based service.
- Staffing Concerns: not enough peer or recognition of family member's contribution. Concerned that the staffing model is too focused on professionals and not enough on peers and family members.
  - Response: Washington has decided to go with the model described in the National PACT Standards which specifies a particular staffing model. One way to meet both needs is to staff based on qualifications, but yet these individuals may also be peers and/or family members.
- Overall concerns about fidelity to the model vs. having more involvement of consumers and families as providers on PACT teams:
  - Response: The way the model is implemented will also come down to local values within each RSN service area. You can maintain adherence to the National Standards, but there may also be some variation within that.
- Controversy about what works and what doesn't work. One participant reported evidence that the model doesn't work. Didn't hear any tangible differences between PACT and other services; it's just a group of people supporting a person and that's why it "works." It doesn't have to include Master's-level providers. I think it's important to examine why PACT works – Is it about a group of people who provide social support for the individual or is it the services themselves?
- Recovery is still individual. Doesn't mean "middle class" outcomes
- It will be important to define "vocational experience and training" for the role of the Vocational Specialist. This will be a critical position.
- In the list of various types of services, I don't see a spiritual component.
- It would be helpful if you added the number of teams to slide 24.
- Note – creating PACT beds in order to reduce number of hospital beds
- I anticipate that there will be more need than the slots available.
  - Response: If the demand is there, we may need to re-examine whether to expand to more teams.
- Is the priority to patients discharged from state hospitals?
  - Response: Our stand (at MHD) is that individuals need to meet the admission criteria specified in the Standards. Individuals don't need to be on an inpatient unit to meet the admission criteria; yet, each RSN does have the requirement to reduce state hospital use.
- Who operates/runs the PACT teams? The RSN or contracted providers?
  - Response: You need a license to operate services and to my knowledge RSN's don't have a license. Most RSN's are contracting out the services to providers.
    - Have to have a license may lead to contracting out

    (Nov. 3rd proposal from RSN's regarding pact) *….this is unclear*

- What is the typical age? Can youth be served?
  - Response: PACT is typically for adults (18+). There are some teams that are focusing on transition-age youth, but these are young teams and there are no known data to date.
- Are there studies regarding relevance to other cultural groups?
  - Response: This is a huge gap for all EBPs, including PACT.
- At what point do you develop another team? What happens to the 101st client?
  - Response: King County plans to address by slightly increasing staffing to maintain the appropriate staff-to-client ratio.
- Related to this last comment, you really need to be clear about what you're communicating to the community about whether PACT is an "entitlement" or just like any other service and therefore when they're full, they're truly full. This both an important community message as well as a potentially big legal issue.
  - Response: We have to remember that the number of teams is based on the assumption that this is the amount of demand.
- Cultural competence: It's easy to talk about how training can address this need, but it does not guarantee or build cultural competency. We need to think about putting together specialized teams located within diverse communities.
- I noticed that you had "assistance with ADL's" listed as one of the PACT services. What do those include (and how are they different from the older adult world)?
  - Response: Assistance with ADL's within PACT may include assistance with grooming, finding housing, performing household activities (e.g., kitchen safety), money management, etc.
- Could a PACT team work with someone on COPES?
  - Response: As long as that individual qualifies for both services, then yes.
- Regarding training and curriculum development, who does that and how will consumers and families be involved?
  - Response: The lead trainer will be Debbie Allness, who developed the National PACT Standards and does training through NAMI at the national level. The role of consumers and families will be locally determined based on input and development of the local Stakeholder Advisory Groups (on the last page of the draft Washington PACT Standards).
- Who will be conducting the fidelity reviews?
  - Response: For the first 1 ½ to two years, the WIMIRT team will conduct these reviews, which will then transition to MHD thereafter.

PACT BRAINSTORM: What do we need to do to ensure that the process for developing and implementing PACT teams is complete, thorough, and credible?

- If other PACT teams are implemented (in addition to those planned), would training be available to support those other teams?
- Regarding the list of outcomes (slide #23), add decreased use of illegal substances and safety (we've specifically had a lot of problems with fire safety)
- Richard Kellogg: We need to make sure there is consumer involvement in the hiring process.
- More emphasis on reducing hospitalizations
- Additional feedback on the outcomes: Outcomes external to the consumer are a huge concern. Shouldn't the focus be on the consumer's life?

    - Response: In early 2007, we may want to consider an evaluation team that includes consumers and families so that we can better address the question of "What meaningful questions do you want the data to answer?"
- Need to recognize focus on changing/stabilizing people's lives
- Success with the PACE-T program is relevant to what the person had before. Can't be a long term thing. PACT is successful but at what cost?
- Proposing to do study following earlier groups
- Legislative – desire to invest in community resources and a wish to invest in a specific initiative.
- Richard – common thread of illness management and recovery services can define the benefits.
- Need to focus on education to consumers – what PACT can and can't do
- Concerns for future funding and housing. Is this going to be blended into rates? If we don't find a way to reimburse for it, that will have a bad impact on the sustainability of the program.

SUGGESTIONS FOR THE FORUM QUESTIONS:
The task force provided feedback along the way during discussion of PACT, so many of their concerns were discussed before this point. They were happy with the suggested questions for the forum, which are:
- What outcomes are most important for PACT?
- What concerns should we be watching for?
- How do we ensure a person-centered, recovery-oriented model within the framework of PACT?

BENEFITS PACKAGE

Concerns and Questions:
- Slide #29: Regarding State only FY 07 RSN funding at $105 million – should note that most of this is directed or dedicated (e.g. jails)
- I'm getting the feeling that the legislature doesn't want a lot of requests for new money this year, so what they are doing now is covering ground/ backfilling to where we should have been in the first place…so no real net gain.
    - Response: This is more than backfilling.
- We are so much further than we were 3 or 4 years ago. We are a much better mental health system now.
- Slide 31: Regarding issues with current package: Our concern or issue is about the definitions of the services themselves, such as:
    - Intake
    - Clubhouse: The requirements are inconsistent with the national clubhouse association's requirements.
    - Rehab case management: Most people don't code for case management because of the definition. Language can be very confusing given what was allowed. Still not crystal clear, probably won't go away as long as we are under CMS' definitions.
- Slide 32: Some RSN's are very small and do not have enough critical mass for all services.
- People with the right services don't have to become Medicare eligible.
- When you're talking about the current benefits package or suggested changes to it, are you talking about defining modalities or services and specific EBPs?

    - Response: We have to stick with modalities because of the way CMS defines it. Within or underneath each modality category, you have certain EBPs. So, we will be looking at what EBPs are out there that we want the definitions to include.
- Hope to know which children are getting served.
- This project should also address the access to care standards.
- 3 contracts with RSN's - does this apply to all contracts? Federal money (we pay to all)
- I want to remind you all about the budget detail in our packet which provides the scope for this study.
- Washington is a pretty open system about who gets in for services. We might want to think about a "level system" with the benefits package redesign.

BENEFITS PACKAGE BRAINSTORM: What do we need to do to ensure that the process for redesigning the Benefits Package is complete, thorough, and credible?

- Might want a focus group of line staff clinicians. We should ask them "what is it that you need and what you are doing that doesn't fit into the boxes?"
- Revisit the case management definitional problem
- Yes, the "case management" term has become meaningless
- Transferred people talking about recovery/resiliency. People get kicked out because they no longer "need" the system. Need to include natural supports (e.g., housing and employment, spirituality). How do we show that?
- There is no measure for access.
- How the contract is structured can direct services (rather than need directing the services).
- We need to figure out what other states are doing.
- Access means people with disabilities getting what they need or people who can't get to the office.

SUGGESTIONS FOR THE FORUM QUESTIONS:

- Original forum questions:
    - What five services are most supportive of recovery/resiliency? (Which benefits do you want to keep?)
    - What five services are least supportive?
    - What services are missing?
- Let's merge the first two questions.
- Are any of the current service definitions barriers? What modifications?
- Clarify the words we are using – Should we be saying "services" or "modalities?" We need to compare apples to apples.
- Ask people if they have access to any of the current services in the benefits package.
- Take off the 3rd question
- Add: In our current definitions are there barriers to access?

#1 Substitute "What works for you in your recovery?

- Caution – don't want to be so high level that we lose sight of what we need (i.e., focus isn't on an actual modality that is included in the benefits package and is instead about the kinds of supports that can't be included in the benefits package).

#2 Access what are the issues?

#3 Are there barriers that exist in the definitional issue?

- Amy – Have to let people talk about access. But have to work toward what the legislature is asking for in the budget detail.

- Andy – We have to be clear about the specificity we are looking for (related specifically to the benefits package) when we ask this question. We don't want to raise expectations that can't be delivered because of the limited scope and focus of this study.
- I'd recommend a "devil's advocate" process regarding which ideas move forward and which do not.
- Can we bring the work of the Mental Health Transformation Grant process to the forum?
- Andy – The issue is one of time. Consultants will review all the materials gathered by the T-grant. Let's talk about how we can bring that information to the group without causing confusion or diverting the focus.
- JoAnn – Transformation Grant did not cover the definition issues, so these questions are definitely different.

~~Final agreed upon~~ Suggested questions for the November forum:

- What services and supports work for you in your recovery?
- What access issues exist related to what works for you in your recovery?
- Are there barriers that exist because of the definitional issue?

HOUSING

Concerns and Questions:

- How do we shape housing resources to facilitate recovery?
- Housing is key – the greatest service package won't matter without housing.
- Need some emphasis on assistance for people who are going through breaks in stability and loosing their housing during that time.
- Trauma histories affect stability too.
- Permanent has to mean the back end when people recover so that they don't lose ground.

HOUSING PLAN BRAINSTORM: What do we need to do to ensure that the process for developing a mental health housing plan is complete, thorough, and credible?

- We have to remember that the cost of rental housing is prohibitive. I'm also worried about coming up with costs of supports for people in housing.
- This is not something MHD can solve. We need other departments and players involved.
- SSI payments are nearly the same statewide but what you can buy is completely different. We may need to change benefit levels to fit with housing prices.
- Need to identify how much of the different types of housing are needed in each community.
- Is MHD involved in the statewide homeless effort?
- When you get the housing resources, which consumers will have access to it? What will be the criteria?
- Have to address the difficulty of building housing that fits with and meets the needs of individuals with mental health issues.
- Can we address the "awful" group homes that we already have?
- Have to address the other unanticipated funding issues. Sometimes our consumers are very hard on our homes. There is a high cost for maintenance.

SUGGESTIONS FOR THE FORUM QUESTIONS:

- Original forum questions:
  - What housing models support recovery?

    - What would you change to make the housing models more person-centered and recovery-oriented?
    - What housing outcomes should the system measure?
- The first question – don't we already know the answer?
- Actually, we all may know the answer in this room, but will a larger group know the answer to the first question on specific housing models?
- What barriers are there to getting and keeping housing that works?
- What kind of housing works best?
- What doesn't work?
- Why can't we provide suitable housing for people with mental health issues? You get different answers depending on the perspective.
- Comes down to:
    - Getting housing vs. maintaining successful housing.
    - Talking about practical issues like keeping people from smoking in bed or dealing with them when they do.

~~Final agreed upon~~ Suggested questions for the November forum:

- What barriers are there to obtaining and maintaining recovery-oriented housing?
- What are the supports that are needed to obtain and maintain recovery-oriented housing?
- What housing outcomes should the system measure?